

Case Number:	CM15-0160880		
Date Assigned:	08/27/2015	Date of Injury:	10/15/2011
Decision Date:	09/30/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	08/17/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Utah, Arkansas

Certification(s)/Specialty: Family Practice, Sports Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 54-year-old female with an industrial injury dated 10-15-2011. The injured worker's diagnoses include closed vertebral fracture, thoracic and lumbar spinal stenosis, and closed neck fracture of femur status post placement of baclofen infusion pump. Treatment consisted of lumbar Magnetic Resonance Imaging (MRI), X-rays, computed tomography of the abdomen, surgical procedures, prescribed medications, permanent baclofen pump placement, manual wheelchair, epidural injection, physical therapy, home health care and periodic follow up visits. In a progress note dated 08-04-2015, the injured worker reported continued low back pain and hip pain. The injured worker rated low back pain a 6 out of 10 with radiation to the bilateral lower extremities. The injured worker also reported incontinence and difficulty with ambulation. Objective findings revealed no swelling or tenderness in any extremity and normal muscle tone without atrophy in upper and lower extremities. The treating physician noted that the injured worker was in a wheelchair during visit. The treatment plan consisted of home health care assistance, medical supplies, medication management and follow up visit. The treating physician requested services for additional 3 months of outpatient home health care, now under review.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Home health care additional 3 months, outpatient: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health, Page 51.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Home health care. MTUS guidelines state the following: Home health services. Recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. (CMS, 2004) The patient does meet the criteria for home health based on the history. However, the current request does not specify the current hours per week requested. Within the documents, it is noted as 7 days a week for 8 hrs a day. This would exceed the "no more than 35 hrs a week" recommended. According to the clinical documentation provided. Home Health-care is not indicated as a medical necessity to the patient at this time.